Great-West℠ HEALTHCARE

MEDICAL CLAIM FORM

PART A - MEMBER STATEMENT - Failure to Answer All Questions May Delay Payment

1. Member's Name | Street Address | City or Town | ZIP Code

2. Plan Number 050703 | Social Security # | Are you still employed? ☐ Yes ☐ No | If no, enter date last worked

3. Date of Birth | Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed | Name of Your Employer: CITY OF LONG BEACH | Occupation

4. Spouse's Date of Birth | Is your spouse employed? ☐ Yes ☐ No | If yes, enter the name and address of spouse's employer

5. Are you or your dependents covered under another group insurance or government plan such as Medicare, an HMO or automobile no fault coverage, which will also cover any of the medical expenses on the claim? ☐ Yes ☐ No
If yes, enter name and address: _____
Policy # / ID #: _____
Family Member Holding Policy: _____

6. Is claim for a dependent? ☐ Yes ☐ No | If yes, enter dependent name (first, last) | Sex ☐ Male ☐ Female | Date of Birth | Relationship to Member | If dependent is a child, are you entitled to a tax exemption? ☐ Yes ☐ No

6a. If child, is he/she married? ☐ Yes ☐ No | Is child over 19? ☐ Yes ☐ No | If yes, is child a full-time student? ☐ Yes ☐ No | If yes, enter name of school

7. Is claim for an accident? ☐ Yes ☐ No | Date: / / Time: ☐ AM ☐ PM | Where did it occur? | While working? ☐ Yes ☐ No | How did it occur?

8. SIGN HERE IF YOU WANT BENEFITS PAID TO DOCTOR/HOSPITAL | DATE: / /

I hereby authorize any insurance company, hospital, or physician to release all information which may have a bearing on benefits payable under this plan of benefits.

9. SIGN HERE FOR ALL CLAIMS | DATE: / /

PART B - DOCTOR OR SUPPLIER - Complete and Return to Patient

Patient's Name | Date of Birth | Date first consulted for condition | Has patient ever had same or similar symptoms? ☐ Yes ☐ No | Name of Referring Physician

Date patient able to return to work | Dates of total disability From / / Through / / | Dates of partial disability From / / Through / /

Diagnosis or nature of illness or injury. *Relate diagnosis to procedure in column D by reference to numbers 1, 2, 3, etc. or DX Code* | Is condition related to work incurred injury or illness?

1. 2. 3. 4. | ☐ Yes ☐ No

A Date of Service	B Place of Service	C Describe fully procedures, medical services, or supplies furnished for each date given: Procedure Code (Identify:)	(Explain unusual Services or Circumstances)	D DX Code (ID:)	E Charges

Signature of Physician

Signed | Date: / /

Total Charges	Amount Paid	Balance Due

Provider's Social Security # / Tax ID # | Physician's Name, Address, ZIP Code | Telephone (Include Area Code)

Place of Service Codes

1. (IH) - Inpatient Hospital
2. (OH) - Outpatient Hospital
3. (O) - Doctor's Office
4. (H) - Patient's Home
5. - Day Care Facility
6 - Night Care Facility (PSY)
7. (NH) - Nursing Home
8. (SNF) - Skilled Nursing Facility
9. - Ambulance
10. (OL) -
11. (IL) - Independent Laboratory
12. Other Medical/Surgical Facility

Group Medical Claim - HOW TO FILE A CLAIM

Member

1. Complete Part A - One for each family member
2. If claim is for a dependent, also complete lines 6 & 6a
3. If claim is for an accident, complete line 7
4. For all claims, sign line 9
5. If you want benefits paid to doctor/hospital, sign form on line 8
6. Enclose a copy of other carriers' payment worksheet when you have other insurance.
7. Ask your doctor to provide itemized bills with diagnosis for care

Doctor/Dispenser

1. Complete Part B
2. Or, attach Itemized Bill which includes Diagnosis for care
3. Sign form - return to patient

Forward Completed Claim Forms to:
1000 Great-West Drive
Kennett, MO 63857-3749

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against a claims administrator of payer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. Such action is considered to be a felony in some states.

Authorization is valid for the duration of the claim. Claimant or Claimant's authorized representative is entitled to receive a copy of this form.

Great-West Healthcare refers to products and services provided by Great-West Life & Annuity Insurance Company and its subsidiaries (Alta Health & Life Insurance Company and Great-West Healthcare HMO/HCSC companies). It also refers to the group business that is underwritten by New England Life Insurance Company and Metropolitan Life Insurance Company which is currently administered by Great-West Life & Annuity Insurance Company. Great-West Life & Annuity Insurance Company is not licensed to do business in New York. Products are sold in New York by its subsidiary First Great-West Life & Annuity Insurance Company, White Plains, N.Y.